STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DULL DIVIS		(X3) DATE SURVEY COMPLETED			
		155786	A. BUILDING B. WING		04/27/2012		
NAME OF I	DOLUDED OD GUDDUE	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	ı		
NAME OF I	PROVIDER OR SUPPLIE	K	10312 ALLISONVILLE RD				
ALLISON	IVILLE MEADOWS	3	FISHE	RS, IN 46038			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE		
F0000	REGULATORT OF	R ESC IDENTIFTING INFORMATION)	TAG		DATE		
1 0000							
	This visit was fo	or a Recertification and	F0000	This provider respectfully			
	State Licensure	Survey. This visit		requests that the 2567 Plan o	f		
		gation of Complaint		Correction be considered the Letter of Credible Allegation a	and		
	IN00107010.			requests a Post Survey review			
				or after 5/27/12.			
	Complaint IN00	0107010 - Substantiated.					
	Federal/State de	eficiencies related to the					
	allegations are c	eited at F323.					
	Survey Dates:						
	April 23, 24, 25	, 26, and 27, 2012					
	Facility Number						
	Provider Number						
	AIM Number: 2	201014060					
	Survey Team:						
	Heather Lay, R	N - TC					
	Janet Stanton, R	LN .					
	Michelle Hostet	er, RN					
	Melanie Strycke	er, RN					
	Census Bed Typ	oe:					
	SNF: 23						
	SNF/NF: 97						
	Total: 120						
	Camana Darras T						
	Census Payor Type:						
	Medicare: 23						
	Medicaid: 66						
	Other: 31 Total: 120						
	10tal. 120						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155786		A. BUILDING B. WING	00 	COMPLETED 04/27/2012			
	ROVIDER OR SUPPLIER VILLE MEADOWS	10312	STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
IAU	Sample: 24 Supplemental sample: 1 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/02/12 by Suzanne Williams, RN	y TAU		DAIE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FFN111

Facility ID: 012466

If continuation sheet Page 2 of 45

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155786	04/27/2012				
			B. WING				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
			10312 ALLISONVILLE RD				
ALLISON	IVILLE MEADOWS		FISHE	RS, IN 46038			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DE CAMPANA DA LA CE CONDECCIONA	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE		
F0225	483.13(c)(1)(ii)-(i	iii) (c)(2) - (4)					
SS=D	INVESTIGATE/F						
00 5	ALLEGATIONS/						
		not employ individuals who					
		guilty of abusing,					
	neglecting, or mi	streating residents by a court					
	of law; or have h	ad a finding entered into the					
		registry concerning abuse,					
	_	ment of residents or					
		of their property; and report	1				
		t has of actions by a court of					
	_	mployee, which would					
indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide							
	registry or licens	ing authorities.					
	The facility must	ensure that all alleged					
	_	ng mistreatment, neglect, or					
		injuries of unknown source					
		ation of resident property are					
		ately to the administrator of					
		o other officials in accordance					
	•	rough established					
		uding to the State survey and					
	certification ager						
	The facility must	have evidence that all					
	alleged violations	s are thoroughly investigated,					
	and must preven	t further potential abuse					
	while the investig	gation is in progress.					
		investigations must be					
	•	dministrator or his					
		esentative and to other					
		dance with State law	1				
	, ,	State survey and certification					
		working days of the incident,					
	•	d violation is verified					
	* * * *	ective action must be taken.	E0225	F0005 4 \A" ' '	05/27/2012		
		review and interview, the	F0225	F0225 1. What corrective	05/27/2012		
	facility failed to	report an allegation of	1	actions will be accomplished for)ľ		
			<u> </u>	those residents found to have			

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Event ID: FFN111

Facility ID: 012466

If continuation sheet Page 3 of 45

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLI	ETED
		155786	A. BUIL B. WING			04/27/	2012
			b. whee		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS		FISHERS, IN 46038				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	·		DATE
		he State agencies, and			been affected by deficient practice? The CNA was		
	during an abuse	investigation the alleged			terminated on 3/6/12. All staff	.	
	violator was not	immediately suspended			have been educated on 5/8/12		
	from work or rea	ssigned. The deficient			regarding Abuse, and abuse	_	
	practice impacte	d 1 of 2 residents			reporting. Social Service will		
	-	eged abuse violations			follow up with #115 for any		
		mple of 24 residents			psycosocial needs she may		
	reviewed. [Residue]	•			have. She will also call the far		
	l leviewed. [Kesi	uent #113]			weekly for 4 weeks to ensure concerns will be prombtly	any	
Findings include:				identified and resolved. 2.How	,		
				other residents having the	·		
					potential to be affected by san	ne	
	During entrance	conference on 4-23-12 at			deficient practice will be identi		
	10:15 A.M., the	facility's abuse			and what corrective actions wi		
	prohibition polic	y and procedure and 2-3			be taken? All residents have the	he	
		f alleged abuse violations			potential to be affected. A		
	_	rom the Executive			mandatory inservice held on 5/8/12 regarding Abuse and		
	_	pletion of the "Abuse			Abuse reporting was held . All		
	Prohibition Proto	•			potential allegations of Abuse		
	Prombinion Prod	DC01.			be reported timely to the Direct		
		20.436.4.5			of Nursing and the executive		
		0:30 A.M., the Executive			Director for investigation and		
	•	d the facility's "Abuse			reporting per policy. Any	.	
	Prohibition, Rep	orting, and Investigation			employee that is alledged will		
	Policy and Proce	edure," dated February			suspended immediately pendi outcome of investigation. 3. W	-	
	2010. At that tir	ne, the abuse policy and			measures will be put in place		
	procedure was re	eviewed and included, but			what systematic changes will I		
	*	o, a definition of verbal			made to ensure that the defici-		
					practice does not recur? Any		
	abuse as follows: "Verbal Abuse - defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to				alledged Abuse will be		
					investigated immediately per		
					Abuse protocol by the ED/ or Designee and reported to ISD	н	
					and other entities per policy.		
		families, or within their			mandatory inservice was held		
	hearing distance	Examples would			5/8/12 on Abuse, Abuse repor		
	include, but are i	not limited to: threats of			and allegations of abuse. All	-	
	harm, saying thin	ngs to frighten a resident			allegations of Abuse will be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ΓED	
		155786	B. WING 04/27/2012			012	
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE		
ALLICON			10312 ALLISONVILLE RD				
ALLISON	IVILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	or scolding an	d/or speaking to them in			reported timely to the Director	of	
	harsh voice tone				Nursing and to the Executive		
	The state of the s				Director for investigation and		
	On 4 24 12 at 0.	00 A.M., the Executive			reporting to ISDH and other		
		· · · · · · · · · · · · · · · · · · ·			entities. The alledged involved	WIII	
	•	d the facility's abuse			be immediately suspended pending the outcome of the		
	_	Resident #115. At that			investigation. ED will ensure a		
	time, a "Residen	t Event Investigation			abuse allegations will be repor		
	Questionnaire" a	nd an "Employee			to ISDH per ASC policy. All		
	Communication	Form" were reviewed.			allegations of abuse/employee		
	The "Resident Event Investigation				misconduct will be reviewed w	ith	
					the Director of Operations to		
		ncluded, but was not			ensure abuse policy is followed	d	
	`	*			including reporting to ISDH.	an l	
	· ·	dent Name: [Resident			4.How the corrective actions was be monitored to ensure the	/	
	_	of Event: 'Res Abuse'			deficient practice will not recur	2	
	[with a line draw	n through both words,		To ensure compliance the DNS/			
	and written next	were the words] 'Staff			or designee is responsible for		
	attitude' Date	of Event: 3-2-12			completion of the Abuse CQI t	ool,	
	Summary of Inv	estigation: CNA said to			weekly for 4 weeks, bi-monthly	/ for	
	i -	t, 'You keep asking me			2 months and quartley until		
	_	* -			compliance is maintained for 2	I	
	1	I told you I will do it			consecutive quarters. the resu		
	_	I'm busy.' CNA was just			of these Audits will be reviewe		
	hired. This attitu	ide is not tolerated by			by the CQI committee oversee by the ED. if threshold of 100°		
	management."				not achieved an action plan wi		
					be devloped to assure		
	The written narra	ative of the investigation			compliance. Completion date		
		ve Director included, but			5/27/12		
	was not limited to, the following information:						
	On 3-2-12, at 12:00 P.M., ED/DNS						
	[Executive Direct	tor/Director of Nursing					
	Services] notifie	d of the incident.					
	On 3-2-12, at 3:0	00 P.M., MD [Medical					

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Event ID: FFN111

Facility ID: 012466

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE SI COMPLE	
AND FLAN	OF CORRECTION	155786		LDING		04/27/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
1710		fied of the incident.		1110			DITTE
	On 3-2-12, at 3:00 P.M., Family was notified of the incident.						
	Written nevt to "	ISDH notified date" was					
	"N/A [Not applied						
	Caragra						
	Written next to "APS notified date" was						
"N/A."							
	Written next to "Ombudsmen notified						
	date" was "N/A."						
	A written statem	ent by LPN #13 with no					
		d indicated, "CNA [#14]					
	_	ining room and said to					
		a keep asking me the I you I'll do it when I get					
	_	CNA left dining room,					
		aid to a resident, 'I wish I					
		you in here.' I then called					
	CNA to hallway.	explaining to her this					
		riate way to speak to a					
		d, 'OK, thanks' and					
	walked away."						
	A written statem	ent by LPN #3 with no					
		d indicated, "On 3-2-12,					
		NA walked into assist					
	_	told a res [resident] 'she					
		I just leave her in here.'					
	-	mediately spoke to CNA					
	about her comme	ent/behavior."					

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Event ID: FFN111

Facility ID: 012466

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED				
711.12 11.111	o. condensity	155786	A. BUILDING		04/27/2012			
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIEF	8	10312 ALLISONVILLE RD					
ALLISON	IVILLE MEADOWS		FISHE	FISHERS, IN 46038				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE			
TAG	REGULATORT OR	LISC IDENTIFTING INFORMATION)	TAG	Dia relation	DATE			
	A written statem	ent by DNS dated 3-6-12						
	and titled "Summary of the Alleged							
		tion" indicated "DNS and						
	_	irector concluded the						
	investigation. It	was discovered that						
	CNA was not be	ing respectful to the						
	resident. It is ag	ainst our policy as ASC						
	to condone any form of disrespectful act by any of our staff to our residents.							
		NA was terminated by						
	DNS on 3-6-12.							
	On 4-24-12 at 13	2:00 P.M., Resident D's						
	record was revie	•						
		re not limited to,						
	-	IDS [Minimum Data Set]						
		ening dated 4-6-12,						
		s not limited to, "BIMS						
		Mental Status] screening						
	score 8 [moderat	te cognitive impairment]						
	Behavioral Sy	mptom - Presence and						
	Frequency: Deli	rium present"						
	A UNIT ST	W.1., 12.0.10						
		s" dated 3-2-12, at 3:00						
	· ·	out was not limited to, name of daughter] re						
	1 1	· ,						
[regarding] staff making inappropriate comments to resident; spoke with resident who had no concerns at this time. Follow								
	up with psyco[sic]-social needs per social							
		otified, no new orders."						
	On 4-25-12, the	DNS provided the						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155786		ON NUMBER:	A. BUILDING B. WING	00	COMPLETED 04/27/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I (EACH DEFICIENCY MUST BE PE REGULATORY OR LSC IDENTIFYII	RCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	facility's time sheet, dated 3-3-30-12. CNA #14 was press [date of alleged abuse allegat 6:42 A.M. to 3:08 P.M. In an interview on 4-27-12, at the Executive Director indica always handled investigation the resident first, then decide report to State agencies. He is otherwise, he'd be reporting of the Executive Director indicated not abuse; it was "staff attitu Director of Nursing indicated employee was terminated. 3.1-28(c) 3.1-28(d) 3.1-28(e)	ent on 3-2-12 ion] from t 1:10 P.M., ited how he s was to ask whether to indicated, every day. t 2:20 P.M., ited this was de." The				

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Event ID: FFN111

Facility ID: 012466

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	
		155786	B. WIN			04/27/	2012
(F. 0F. P				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		10312 ALLISONVILLE RD				
	IVILLE MEADOWS		FISHERS, IN 46038		RS, IN 46038		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	483.13(c) DEVELOP/IMPL ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on record facility failed to or Prohibition Policies agencies, and the their policy relatoresidents during a investigation as the not immediately reassigned during deficient practice residents reviewed violations from a residents reviewed violations from a residents reviewed buring entrance 10:15 A.M., the prohibition policies written reports of were requested fire	the alleged violator was suspended from work or g the investigation. The e impacted 1 of 2 ed for alleged abuse a survey sample of 24 ed. [Resident #115] : conference on 4-23-12 at facility's abuse y and procedure and 2-3 f alleged abuse violations rom the Executive pletion of the "Abuse	F02	26	1. What corrective actions will accomplished for those reside found to have been affected by deficient practice? The CNA v terminated on 3/6/12. All staff have been educated on 5/8/12 regarding Abuse, and abuse reporting. Social Service will follow up with #115 for any psycosocial needs she may have. She will also call the far weekly for 4 weeks to ensure a concerns will be prombtly identified and resolved.2. How other residents having the potential to be affected by sam deficient practice will be identifiand what corrective actions wi be taken? All residents have th potential to be affected. A mandatory inservice held on 5/8/12 regarding Abuse and Abuse reporting was held. All potential allegations of Abuse be reported timely to the Director for investigation and reporting per policy. Any employee that is alledged will suspended immediately pending outcome of investigation.3. When the control of the control of the pending outcome of investigation.	nts / / vas milly any ne ried ll e will tor	05/27/2012
		0:30 A.M., the Executive d the facility's "Abuse			measures will be put in place of what systematic changes will be made to ensure that the deficient	e	

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Event ID: FFN111

Facility ID: 012466

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155786	B. WIN			04/27/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	t .		10312 A	ALLISONVILLE RD	
	IVILLE MEADOWS				RS, IN 46038	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	•	DATE
	, 1	orting, and Investigation			practice does not recur?Any alledged Abuse will be	
	1 *	edure," dated February		investigated immediately per		
	2010. At that time, the abuse policy and				Abuse protocol by the ED/ or	
	1 ^	eviewed and included, but			Designee. a mandatory inserv	vice
	was not limited t	o, a definition of verbal			was held on 5/8/12 on Abuse,	
		: "Verbal Abuse -			Abuse reporting and allegation of abuse. All allegations of Abu	
	defined as the use of oral, written, or gestured language that willfully includes				will be reported timely to the	uo c
					Director of Nursing and to the	
	disparaging and	derogatory terms to			Executive Director for	
	residents or their families, or within their hearing distance Examples would				investigation and reporting to	
					ISDH and other entities. The	
		not limited to: threats of			alledged involved will be immediately suspended pendi	na
		ngs to frighten a resident			the outcome of the	119
	' ' ' '	d/or speaking to them in			investigation.4.How the correc	tive
	harsh voice tone			actions will be monitored to		
	naish voice tone			ensure the deficient practice wil		
	On 4 24 12 at 0.	00 A.M., the Executive			not recur?To ensure complian the DNS/ or designee is	ce
					responsible for completion of t	he
	•	d the facility's abuse			Abuse CQI tool, weekly for 4	
	_	Resident #115. At that			weeks, bi-monthly for 2 month	
		t Event Investigation			and quartley until compliance	is
		nd an "Employee			maintained for 2 consecutive quarters. the results of these	
	Communication	Form" were reviewed.			Audits will be reviewed by the	
					CQI committee overseen by the	ne
		vent Investigation			ED. if threshold of 100% is no	
	`	ncluded, but was not			achieved an action plan will be	•
	limited to, "Residual	dent Name: [Resident			devloped to assure	
	#115] Nature o	of Event: 'Res Abuse'			compliance.Completion date 5/27/12	
	[with a line drawn through both words, and written next were the words] 'Staff attitude' Date of Event: 3-2-12 Summary of Investigation: CNA said to				U.Z./ 12	
	· ·	t, 'You keep asking me				
	_	I told you I will do it				
		-				
		I'm busy.' CNA was just				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		LDING	NSTRUCTION 00	(X3) DATE COMPL 04/27 /	ETED	
	PROVIDER OR SUPPLIEI		10312 A	ADDRESS, CITY, STATE, ZIP CODE ALLISONVILLE RD IS, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)		TE	(X5) COMPLETION DATE
	hired. This attiti management."	ude is not tolerated by				
	from the Execut	ative of the investigation ive Director included, but to, the following				
	[Executive Direction of the Control	:00 P.M., ED/DNS etor/Director of Nursing d of the incident.				
	On 3-2-12, at 3:00 P.M., MD [Medical Doctor] was notified of the incident.					
	On 3-2-12, at 3: notified of the in	00 P.M., Family was acident.				
	Written next to ' "N/A [Not appli	'ISDH notified date" was cable]."				
	Written next to '	'APS notified date" was				
	Written next to 'date" was "N/A.	'Ombudsmen notified				
	date or time note walking out of d one resident 'Yo same thing, I tol done, I'm busy.'	nent by LPN #13 with no ed indicated, "CNA [#14] ining room and said to u keep asking me the d you I'll do it when I get CNA left dining room, aid to a resident, 'I wish I				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155786		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey pleted 7/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
	CNA to hallway,	you in here.' I then called explaining to her this riate way to speak to a d, 'OK, thanks' and						
	date or time note during lunch. Cl dining room and wished she could	ent by LPN #3 with no d indicated, "On 3-2-12, NA walked into assist told a res [resident] 'she d just leave her in here.' mediately spoke to CNA ent/behavior."						
	and titled "Sumn Abuse Investigat Social Service D investigation. It CNA was not be resident. It is ag to condone any f by any of our sta	ent by DNS dated 3-6-12 hary of the Alleged ion" indicated "DNS and irector concluded the was discovered that ing respectful to the ainst our policy as ASC form of disrespectful act ff to our residents. NA was terminated by						
	record was revie included, but we dementia. An M assessment scree included, but wa [Brief Interview	•						

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Event ID: FFN111

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155786	B. WIN			04/27/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .		10312 A	ALLISONVILLE RD		
	IVILLE MEADOWS				RS, IN 46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	1	mptom - Presence and					
	Frequency: Deli	rium present"					
	A "Nurses Notes" dated 3-2-12, at 3:00						
	P.M., included, but was not limited to,						
		name of daughter] re					
	[regarding] staff	making inappropriate					
	comments to res	ident; spoke with resident					
	who had no conc	eerns at this time. Follow					
	up with psyco[sic]-social needs per social						
	services. MD notified, no new orders."						
	On 4-25-12, the	DNS provided the					
		eet, dated 3-1-12 through					
	1 *	414 was present on 3-2-12					
		abuse allegation] from					
	6:42 A.M. to 3:0	• •					
	0. 12 71.111. to 3.0	0 1 .141.					
	In an interview o	on 4-27-12, at 1:10 P.M.,					
		rector indicated how he					
		nvestigations was to ask					
	1 *	then decide whether to					
	· ·	gencies. He indicated,					
	^ -	be reporting every day.					
	offici wise, fie u u	c reporting every day.					
	In an interview o	on 4-27-12, at 2:20 P.M.,					
		rector indicated this was					
		s "staff attitude." The					
	· · · · · · · · · · · · · · · · · · ·						
	Director of Nurs	-					
	employee was te	immated.					
	2 1 29(a)						
	3.1-28(a)						

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PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155786		A. BUILDING B. WING A. BUILDING B. WING A. BUILDING B. WING A. BUILDING B. WING B. WING A. BUILDING B. WING				
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO ALLISONVILLE RD	DDE	_
	IVILLE MEADOWS			RS, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE

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Event ID: FFN111

Facility ID: 012466

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155786		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/27/2012		
	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ALLISONVILLE RD RS, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0248 SS=E	483.15(f)(1) ACTIVITIES MEI EACH RES The facility must program of activi accordance with assessment, the mental, and psycresident. Based on intervie facility failed to poutside of the fact activity program, interviewed in a deficiency had the residents physical participating in a of 120 residents of facility. [Resider and #92] Findings include In interviews dure 4/25/12 at 2:00 Per 469, #1, #90, and facility had not per places like restaut stores/malls, or ovenues of interestindicated she had about 13 months offered a trip of a residents indicated she facility indicated she had about 13 months offered a trip of a residents indicated she had a stores indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 13 months offered a trip of a residents indicated she had a shout 14 months offered a trip of a residents indicated she had a shout 14 months offered a trip of a resident sh	provide for an ongoing ties designed to meet, in the comprehensive interests and the physical, chosocial well-being of each ew and record review, the provide trips to venues cility as part of the to 6 of 11 residents group setting. This he potential to affect 53 ally capable of an extended trip or outing, currently residing in the ents #9, #88, #69, #1, #90, the first f	F024		1. What corrective actions will accomplished for those resider found to have been affected by deficient practice? We have a transportation director who will coordinate with the activity Director to ensure a schedule implemented for resident outin Resident #1,90, and 92 have participated in our outings on M4th an May 10th. Resident #8 refused to go, and resident These outings will occur on a monthly basis. 2. How other residents having the potential to be affected by same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. a schedule has been implement for outside outings on a month basis. This schedule will be communicated to all residents during resident council meeting be held on May 29, 2012. Activities a communicate with residents during his one one visits. This will also be put the calender on a monthly basis. 3. what measures will be in place or what systematic	is gs. May 8 to ed ly g to vity en on	05/27/2012
	to go somepiace	outside of the identity,			changes will be made to ensur	е	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155786	B. WIN	G		04/27/	2012
NAME OF B	DOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	S		10312 A	ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	and when each h	ad asked about going			the deficient practice does not		
	somewhere, they were told "We're				recur?The ED/ or designee wil monitor the schedule outing	ı	
	considering that,	" or "We're working on			program monthly to ensure		
	it." They were a	lso told that the facility			residents are given a choice of	า	
	transport van wa	s not running or needed			wheather to participate in outir		
	some kind of rep	-			or not.4 How the correction ac	tion	
					will be monitored to ensure		
	The Activity pro	gram calendars for			deficient practice will not recur The participation record and fie		
	-	y, March, and April,			trip booklet will be updated to	- 10	
	1	wed. There was no entry			show residents who have		
		•			participated in outings. The		
	listing a trip to any venue outside of the				activity outing booklet will be		
	facility in any of	the 4 months.			reviewed monthly for 4 months	s to	
		4/16/10 + 0.50 + 3.5			ensure outside activities are taken place. the results of thes	. Δ	
		on 4/16/12 at 9:50 A.M.,			audits will be reviewed by the		
		ector indicated he had		committee overseen by the ED. it			
	_	tion only since about		threshold of 100% is not achieve			
		112. He had previously			an action plan will be develope	ed	
	worked in the fac	cility as an Activity			to assure compliance.		
	assistant. He ind	licated that during his					
	Activity Director	training he became					
	aware activities	were required to be					
	provided outside	of the facility, and had					
	started to plan so	ome trips. He indicated					
		ad needed some parts for					
	l *	was now completed. An					
	_	of transportation had not					
		The Activity Director					
	_	far as he was aware, the					
		Director had never					
	l - ·	anged any tripshe did					
		inged any urpslie did					
	not know why.						
	2 1 22(b)(2)						
	3.1-33(b)(3)						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
ANDILAN	OI CORRECTION	155786	A. BUILDING	00	04/27/2012		
			B. WING	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	₹		ALLISONVILLE RD			
ALLISON	IVILLE MEADOWS			RS, IN 46038			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED	
		155786	A. BUII			04/27/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ALLICON					ALLISONVILLE RD RS, IN 46038		
ALLISON	IVILLE MEADOWS			FISHER	RS, IN 46036		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.				1. what corrective action will be accomplished for those residents found to have been affected by the deficient practice?the wheel chair scale has been cleaned and put on a daily cleaning assignment to ensure cleanliness. 2. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected.		05/27/2012
					we will review the wheel chair scale cleaning schedule 3 times a week during morning meeting to ensure compliance. The wheel chair scale is placed on a daily cleaning schedule by the housekeeping department. 3. what measures will be put into		
	on 4/24/12 at 10	fused and ambulatory or elchair without assistance. :00 A.M., environmental with the Maintenance			place or what systemic change will be made to ensure that the deficient practice does not rec On 5/8/12 the SDC inserviced staff on wheel chair scale cleanliness and the new wheelchair scale cleaning	e	
	On 4/24/12 at 10 scale was observ 100. The wheeld debris that appea	:10 A.M., a wheelchair ed in the hallway of unit chair scale had scattered red to be food crumbs as wn, dirt-like matter on			schedule. The housekeeping Supervisoer will ensure the scales are clean.4.how the corrective actions will be monitored to ensure the deficie practice will not recur?the whe chair scale cleaning schedule be reviewed 3 times a week for	el will	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155786		A. BUILDING B. WING	00 	COMPLETED 04/27/2012	
	ROVIDER OR SUPPLIER VILLE MEADOWS	10312	ADDRESS, CITY, STATE, ZIP CODE ALLISONVILLE RD RS, IN 46038		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
TAG	both sides of the scale. At that time, in an interview, the Maintenance Supervisor indicated the wheelchair scale needed cleaned. 3.1-19(f)	TON) TAG	the first month and then weekl for the second month and ther monthly thereafter for at leasr months. The results of these audits will be reviewed by the committee overseen by the EU threshold of 100% is not achie an action plan will be developed to assure compliance	y n six CQI D. If	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155786	B. WIN			04/27/	2012
NAME OF I	DROVIDED OD GUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	-		10312 A	ALLISONVILLE RD		
	IVILLE MEADOWS				RS, IN 46038		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY		DATE
F0323 SS=G	The facility must environment rem hazards as is poreceives adequa assistance device. A. Based on obsignad interview, the implement approact to prevent injury identified as high. This deficient pracesidents reviewed 24 residents reviewed 24 residents reviewed 24 residents. This dimpacted 3 of 5 upotential to affect residing in the facilitation in the facilitation with a were ambulatory wheelchair without C. Based on obsignad interview, the sharp objects on This deficient praces affect 36 resident dementia unit wheelchair without the sharp objects on the facilitation of the sharp objects on the facilitation of the sharp objects on the facilitation of the sharp objects on the sharp objects of the	ensure that the resident trains as free of accident sains as free of accident saible; and each resident te supervision and es to prevent accidents. The ervation, record review, the facility failed to apriate fall interventions of a resident who was a fall risk on admission. The actice affected 1 of 13 and for falls in a sample of the ewed. [Resident N] The ervation, record review, the facility failed to the emicals out of reach of the emicals out of reach of the emicals of the emi	F03	23	1.What corrective action will be accomplished for those resider found to have been affected by the deficient practice? A new firisk assesment was completed resident N on 5/9/12. along with care plan review with current interventions. An inservice was held with all staff members on 5/8/12 regarding proper storage of chemicals (hand sanitizer, and deoderizer) and sharp objects being secured from our resident population. 2. How other residents having the potential side affected by the same deficit practice will be identified All residents have the potential to affected. A new fall risk assesment was completed for residents. IDT will review falls interventions Monday-Friday to ensure that interventions are appropriate and adequate. An inservice was held on 5/8/2012 that included fall prevention, all chemicals and sharp object storation of reach of resident. 3. When measures will be put into place what systemic changes will be made to ensure that the deficie practice does not recur? On 5/8/2012, SDC in-serviced all staffon fall prevention,	nts / all i on th s ee nd r eer to eent be all and c c c c c c c c c c c c c c c c c c c	05/27/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155786	B. WIN			04/27/2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L			ALLISONVILLE RD	
ALLISON	IVILLE MEADOWS				RS, IN 46038	
			_		1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	l `	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE
without assistance of 120 residents				appropriate and adequate intervention to reduce falls or		
	residing in the fa	cility.			injury, all chemicals and sharp	
				objects to be locked out of rea		
	Findings include:				of our residents. Residents wil	
					reviewed by IDT team upon	
	A1. On 4/24/12	at 1:20 P.M., Resident			admission, significant changes	5,
		eviewed. Diagnoses			and on a quarterly and	
		re not limited to, falls,			annual review in order to ensu appropriate interventions are in	
		ve pulmonary disease,			place and are effective. 4, Hov	
		ase, cancer of the			the corrective actions will be	
	bladder, venous				monitored to ensure the deficie	ent
	·				practice will not recur? IDT wil	
	1 ^	ident N was admitted to			review all falls and intervention	ns
	the facility on 3/	1/12.			to ensure intervention are adequate and appropriate, DN	e
					is responsible to ensure fall ris	
	An admission "F	all Risk Assessment," no			management CQI tool is utilize	
	date, included, b	ut was not limited to,			new falls daily for one month,	
	"New Admission	n: yes History of falls:			weekly for the second month,	
	yes Resident re	eceives medications in the			then twice a month for the last	
	following catego	ories: Antihypertensives			month. ED/Designee will be	
	and Narcotics	Resident has diagnosis of			responsible for utilizing a CQI resident rounding tool to monit	or
		ates evidence of impaired			and ensure that chemicals and	
		s Assistive devices:			sharp object are out of reach of	
	1 "	olling walker Resident			residents. This tool will be utilize	zed
		or has history of			three times a week for the first	
	_	•			month, weekly for the second	ho
	non-compliance:	yes			month, and twice a month for third month. The result of this	lie
		C			audit will be review by CQI	
		Minimum Data Set"			committee overseen by the ED). If
	screening dated 3/8/12, included, but was not limited to, "Brief Interview Mental Status [BIMS: 12 [moderately impaired]Section G: Functional Status: Bed mobility, transfer, toilet use, and				the threshold of 100% is not	
					archieve, and action plan will b	
					developed to assure complian	ce.
	personal hygiene	e extensive assistance				
		taff Locomotion on/off				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155786	B. WIN			04/27/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	2			ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS				RS, IN 46038		
			1	<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>	+	TAG	Bertelekery		DATE
	•	ndence with 1 staff					
	person"						
	An "Occupational	al Therapy Progress					
	Report" dated 3/9/12 through 3/15/12,						
	included, but wa	s not limited to, "Patient's					
	progress as follows: Transfer: General:						
		le to safely perform					
	•	• •					
	wheelchair to recliner transfers requiring						
	CG [contact guard assist: contact with						
	patient due to unsteadiness] Reason for continuation of care: Remaining						
		<u> </u>					
		pain, strength, endurance,					
	•	acting ADL [activities of					
	daily living] safe	ety and participation"					
	A "Physical The	rapy Progress Report"					
	dated 3/10/12 th	rough 3/16/12, included,					
	but was not limit	ted to, "Long Term Goal:					
	Supervision with	all functional transfers					
	_	gh fall risk due to					
	,	kness and balance deficit,					
		le lower extremity deep					
		and Coumadin [blood					
	thinner] therapy.	-					
	i ummerj merapy.	••					
	A !!NIi D.:	waga Natasii Jata J					
		ress Notes" dated					
		P.M., included, but was					
	•	Resident is on fall follow					
	_	trying to get to his					
		nd on floor by aide will					
	continue to moni	itor" Documentation					
	was lacking to in	idicate new interventions					
	_	revent further falls.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155786		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 04/27	ETED	
	PROVIDER OR SUPPLIER			10312 A	DDRESS, CITY, STATE, ZIP CODE LLISONVILLE RD S, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	Notes: dated 3/1: included, but wa IDT met for fall 3:35 P.M., reside nurse he was atte his recliner to his found sitting on Resident was plarounding" A "Hourly Roun included, but wa 3/12/12 at 10:00 initiated" A "Fall Care Pla included, but wa "Problem start da [N] is at risk for mobility, cogniti assistance with a Approach Start I in reach, environ personal items we clean/clutter free gripper socks who personal items in rounding, and the There was no "Note the solution of the sol	ding" dated 3/12/12, s not limited to, "Date: A.M hourly rounding n" dated 3/12/12, s not limited to, ate: 3/12/12 Resident fall due to: decline in on issues, needs ll ADL needs Date: 3/12/12: Call light mental changes, keep ithin reach and s, non skid footwear, ten no shoes are worn, a reach, place on hourly					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155786			LDING	NSTRUCTION 00	(X3) DATE COMPL 04/27/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	9:49 A.M., incluto, "IDT met to ron 3/15/12 at 10: an unwitnessed flaying on his back Resident noted to socks on Immediation recersions and the socks on The medication recersions and the socks on the socks of	sical, occupational, and for strengthening" s" dated 3/16/12 added to Care Plan" included, 15 or 24 hours and w" dated 3/16/12, no time, s not limited to, "AMS tatus]/Lethargy due to scontinue Neurontin and to PRN [as needed] gress Notes" dated P.M., included, but was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155786	B. WIN	G		04/27/2012	
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	KOVIDEK OK SUPPLIER			10312 A	ALLISONVILLE RD		
	IVILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE	DATE	
		lted over on his left side					
		nplained of left side pain,					
		fused M.D. and family					
		imentation was lacking to					
		erventions were placed to					
	prevent further fa	alls.					
	A "Nursing Prog	ress Notes" dated					
		A.M., included, but was					
	not limited to, "Resident is confused ambulated self to recliner and dressed self						
	when asked how he got into his recliner						
		e did not remember"					
		was lacking to indicate					
		-					
	further falls.	s were placed to prevent					
	Turtner fails.						
		ss Notes" dated 3/19/12 at					
		uded, but was not limited					
	to, "IDT met for	fall review: On 3/17/12					
	at 3:40 P.M., res	ident had an unwitnessed					
	fall he was fou	nd in his room,					
	wheelchair on th	e floor, tipped over We					
	will remove whe	elchair from room when					
	resident is in roo	m or recliner so resident					
	will not be persu	aded to transfer without					
	assistance"						
	The "Approach"	dated 3/19/12 added to					
		Care Plan" included,					
		elchair from room so he					
	will not try to tra						
		wiio101 0011					
	A "Nursing Prog	ress Notes" dated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155786	B. WIN	G		04/27/2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLI EIER			10312 A	ALLISONVILLE RD	
ALLISON	IVILLE MEADOWS			FISHER	RS, IN 46038	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		A.M., included, but was				
	· ·	Resident noted to transfer				
		recliner [unassisted]				
	Educated residen	t to utilize call light for				
	assistance" Do	ocumentation was lacking				
	to indicate new in	nterventions were placed				
	to prevent further	r falls.				
	A "Nursing Prog	ress Notes" dated 4/1/12				
	at 8:30 A.M., inc	luded, but was not				
	limited to, "Patie	nt [Resident N] was				
	found sitting on t	floor at about 11:45 P.M.				
	in his room pat	ient did indicate pain in				
		r a brief passive range of				
	motion on both u					
		ent assisted back to bed				
	_	patient's son notified"				
	,	, w				
	A "Nursing Prog	ress Notes" dated 4/1/12				
	at 11:30 A.M., in	cluded, but was not				
	limited to, "Resid	dent found to be in				
	extreme pain N	I.D. and family notified				
	_	om to rule out left hip				
	fracture"	1				
	An "IDT Progres	ss Notes" dated 4/2/12 at				
		ded, but was not limited				
	l '	fall review: On 3/31/12				
	· ·	sident found on floor in				
	l '	as in bed prior to fall 15				
	minute checks w	•				
		was lacking to indicate				
		s were placed to prevent				
	further falls.	s were praced to prevent				
	Turnier lans.					ĺ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155786	B. WIN	G		04/27/2012	
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIER			10312 A	ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	On 4/27/12 at 10	:00 A.M., all information					
	regarding fall int	erventions for Resident					
	N were requested	d from the DoN.					
	On 4/27/12 at 1:0	00 P.M., the charting for					
		rly rounding was					
		ther documentation was					
	received regarding	ng fall interventions for					
	Resident N.	-8					
	1105100110111						
	A summary from	the "Nursing Progress					
		Resident N's falls and					
		ced by the facility is as					
	follows:	ced by the facility is as					
	10110WS.						
	 3/11/12 at 3·35 F	P.M., resident [Resident					
		was attempting to					
	transfer from his						
		ell No immediate					
		3/12/12 at 10:00 A.M.,					
	hourly rounding						
	nourly rounding	iiiiiatou.					
	3/15/12 at 10·29	P.M Resident had an					
		in his room found					
		k beside the bed					
	gripper socks on						
		minute checks for 24					
		lication reviewed and					
	decreased on 3/1						
	uccicaseu on 3/1	0/12, 110 tille.					
	3/17/12 at 3:40 E	P.M., Resident had an					
		found in his room in					
		lted over on his left side					
	ine wheelchair th	neu over on ms ien side					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155786	B. WIN			04/27/	2012
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			LLISONVILLE RD		
ALLISON	IVILLE MEADOWS				S, IN 46038		
				<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to the floor On	3/19/12, no time,					
	wheelchair remo	ved from room.					
	3/31/12 at 11:45	P.M., found sitting on					
		Intervention: Assisted					
		n medication 4/1/12 sent					
		om with fractured left					
	hip.						
	The "Nursing Pro	ogress Notes" indicated					
	Resident N was l	hospitalized on 4/1/12 for					
		e and returned to the					
	facility on 4/6/12						
	1acility 011 4/0/12	z at 7.24 I .WI.					
		0.11					
	" " "	following interventions					
	were added to hi	s care plan, "Fall Care					
	Plan" dated 3/12	/12, included "Approach"					
	dated 4/9/12, "be	ed and wheelchair					
	alarms"						
	A2 On 4/23/12	at 2:30 P.M., the facility					
		policy and procedure					
		om the Executive					
	Director.						
	On 4/24/12 at 9:0	00 A.M., the Executive					
	Director provide	d, "Fall Management					
	Program" dated 3	3/10.					
	The "Fall Manag	sement Program"					
	·	•					
	· ·	s not limited to, "Policy:					
It is the policy of American Senior							
Communities to ensure residents residing							
	within the facilit	y will maintain					
	maximum physic	cal functioning through					
	1 * *		1				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 27/2012
	PROVIDER OR SUPPLIER		10312	ADDRESS, CITY, STATE, ZIP CO ALLISONVILLE RD RS, IN 46038	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	the establishmen	t of physical,				
	initiated on the 1 that time, LPN # residents residin history of confus	at 10:30 A.M., tour was 00 unit with LPN #1. At 11 indicated 7 of 20 g on the 100 unit had a sion and ambulated or ir without assistance.				
	locked Memory with LPN #10 . indicated 36 of 3 the locked Memory	2:45 A.M., tour of the Care Unit was initiated At that time, LPN #10 66 residents residing on ory Care Unit had ere ambulatory or used a out assistance.				
	unit was initiated time, LPN #2 ind residing on the 4	:00 A.M., tour of the 400 d with LPN #2. At that dicated 6 of 14 residents 00 unit had a history of ere ambulatory or used a out assistance.				
		0:00 A.M., environmental d with the Maintenance				
	of Puricit Odor I	0:10 A.M., an aerosol can Eliminator was observed ocated on the 100 unit.				

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STREET ADDRESS, CITY, STATE, JUP CODE 10332 A.LLISONVILLE MEADOWS		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 04/2	TE SURVEY MPLETED 27/2012
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION) In an interview at that time, the Maintenance Supervisor indicated he was aware all chemicals should not be left unattended in resident areas. The Maintenance Supervisor removed the chemical from the linen cart. On 4/24/12 at 10:20 A.M., on the locked Memory Care Unit, 2 open 4 ounce bottles of Medi-Pak Performance Instant Hand Sanitizer were observed in an unlocked drawer in a portable baking cart located in the activity area of the unit. At that time, the Maintenance Supervisor indicated all drawers are to be locked in the Memory Care Unit at all times. Staff were made aware by the Maintenance Supervisor and all drawers were then secured. On 4/24/12 at 10:30 A.M., on the 400 Unit, 1 open 4 ounce bottle of Medi-Pak Performance Instant Hand Sanitizer was observed on the medication cart in the hallway of the unit. At that time, in an interview, the Maintenance Supervisor indicated he would remind staff to keep the hand				10312 A	ALLISONVILLE RD	DE	
Maintenance Supervisor indicated he was aware all chemicals should not be left unattended in resident areas. The Maintenance Supervisor removed the chemical from the linen cart. On 4/24/12 at 10:20 A.M., on the locked Memory Care Unit, 2 open 4 ounce bottles of Medi-Pak Performance Instant Hand Sanitizer were observed in an unlocked drawer in a portable baking cart located in the activity area of the unit. At that time, the Maintenance Supervisor indicated all drawers are to be locked in the Memory Care Unit at all times. Staff were made aware by the Maintenance Supervisor and all drawers were then secured. On 4/24/12 at 10:30 A.M., on the 400 Unit, 1 open 4 ounce bottle of Medi-Pak Performance Instant Hand Sanitizer was observed on the medication cart in the hallway of the unit. At that time, in an interview, the Maintenance Supervisor indicated he would remind staff to keep the hand	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE	COMPLETION
Unit, 1 open 4 ounce bottle of Medi-Pak Performance Instant Hand Sanitizer was observed on the medication cart in the hallway of the unit. At that time, in an interview, the Maintenance Supervisor indicated he would remind staff to keep the hand		Maintenance Supaware all chemical unattended in resumaintenance Superhemical from the On 4/24/12 at 10 Memory Care U bottles of Medi-Hand Sanitizer vunlocked drawer located in the acceptance At that time, the indicated all drawer made awar Supervisor and a	pervisor indicated he was cals should not be left sident areas. The pervisor removed the ne linen cart. 2:20 A.M., on the locked nit, 2 open 4 ounce Pak Performance Instant were observed in an in a portable baking cart tivity area of the unit. Maintenance Supervisor wers are to be locked in the Unit at all times. Staff the by the Maintenance				
Maintenance Supervisor indicated he would remind staff to keep the hand		Unit, 1 open 4 or Performance Ins observed on the	unce bottle of Medi-Pak tant Hand Sanitizer was medication cart in the				
C1. On 4/24/12 at 10:20 A.M., on the		Maintenance Sup would remind stands sanitizer locked	pervisor indicated he aff to keep the hand in the medication cart.				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 27/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	locked Memory the kitchenette at metal cookie cut	Care Unit, the drawers in rea were unlocked. 2 ters with sharp edges the one unlocked						
	indicated all drav							
	Safety Data Shee hand sanitizer and the Maintenance	:00 A.M, the Material ets were requested for the d odor eliminator from Supervisor and the chemical storage.						
	Safety Data Shee and odor elimina	200 P.M., the Material ets for the hand sanitizer tor and a document titled were received from the for.						
	Sanitizer" Mater included, but wa "Hazardous Com Ethyl Alcohol into the Body: E Inhalation Sign	ponents: Denatured Possible Routes of Entry						
	redness Swallo	_						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/27	ETED
	PROVIDER OR SUPPLIER		 10312 A	DDRESS, CITY, STATE, ZIP CODE ILLISONVILLE RD IS, IN 46038	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	Inhalation: Poss consciousness"	ible giddiness or loss of				
	The bottle was m Reach of Childre	narked, "Keep Out of en."				
	Material Safety I was not limited t Identification: C irritating to eyes	Jse Odor Eliminator" Data Sheet included, but o, "Hazards aution: May be mildly and skin, may cause mfort, nausea, vomiting,				
		was marked, "Keep Out dren."				
	included, but was cleaning supplies storage rooms remote locations general public ar	d, "Safety" no date, s not limited to, "All s must be kept in locked Cleaning supplies in , i.e., activity room, eas, nursing stations				
	This federal tag i IN00107010.	relates to Complaint				
	3.1-45(a)(2)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155786	B. WIN			04/27/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ALLISONVILLE RD		
ALLISON	VILLE MEADOWS				RS, IN 46038		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.35(i) FOOD PROCUR STORE/PREPAR The facility must (1) Procure food considered satisf local authorities; (2) Store, prepar under sanitary co Based on observa record review, th hair was secured kitchen, and food properly stored, of from possible co use of hair nets h 120 residents wh of 1 kitchen of 12 facility. The imp the potential to a food served in th The improperly s potential to affect in the Cottage un	RE, RE/SERVE - SANITARY - from sources approved or factory by Federal, State or and e, distribute and serve food onditions ation , interview, and e facility failed to ensure in hair nets in the d being served was covered and protected intamination. The lack of had the potential to affect o eat food served from 1 20 residents in the properly covered food had affect 56 residents who eat e 500 hall dining room. Stored food had the t 36 residents who reside iit.	F03	TAG	1.What corrective action will be accomplished for those reside found to have been affected by the deficient practice? An inservice was held on 5/1/12 all dietary employees on prope securing all of the hair in a hairnet, and proper covering of food served to our residents. 2. How other resident having the potential to be affect by the same deficient practice be identified and what correcting action will be taken? all resident have the potential to be affect an inservice was held on 5/1/1 with all dietary employees ensuring that all of the haie is secured in the hairnet as well at the proper covering of food ite and ensuring utensils are not lin storage bins. 3. What measure were put in place or systemic changes will be made to ensuring the made to ensure the made to ensure the made to ensure the made to ensure the mad	e nts y for erly f ts cted will on nts ed. 2 as ms eft ures	
	4/23/12 at 10:10	A.M. during tour, Cook			that a deficient practice doe no		
		have several hairs			recur?daily rounding by the		
		e bottom of her hair net			dietary manager to ensure die		
	while preparing f				staff properly secure there hair	r	
	willie proparing i	oou.			and coverage of food being		
	_	vation in the kitchen on A.M. Cook #12 was			served. she will also monitor storage bins to ensure utensils are not left in the bins.4.How the corrective action will be monitor	he	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155786	B. WIN			04/27/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER				ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS				RS, IN 46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	DATE	
		nen working with food			to ensure the deficient practice will not recur?To ensure	,	
	and her hair was not secure in the hair net.			compliance the dietary manager	er		
					will monitor staff daily for secu		
	During an observ	vation on 4/25/12 at			all hair under hairnet, proper		
	11:20 A.M. Cool	k #9 was cooking the			coverage of food being served	,	
	food and checkir	ng temperatures of the			and utensils left in storage bins. this will be monitored dai		
	food and was no	ted to have one large			for 4 weeks, and then weekly f	,	
	strand of hair hai	nging out of her hair net.			one month and then 2 times a	<u> </u>	
		lso had several strands of			month thereafter, The dieticia		
	hair sticking out of the back of her hair net.				will review this on a weekly ba		
					to ensure compliance, the resu		
					of these audits will be reviewed by the CQI committee oversee		
	During environm	nental tour on 4/24/12 at			by the ED. if the threshold of		
	_	Cottage kitchen was noted			100% is not achieved an action	n	
		d metal container of		plan will be developed to assure compliance.		re	
	_	op of the refrigerator.					
	Inside of the met	al container was a spoon.					
	During the lunch	hour in the 500 hall					
	dining room on 4	4/24/12 at 12:30 P.M.					
	There were two,	three tier carts with					
	desserts on them	. The cart in the middle					
	dining room was	wheeled around from					
	_	ent to choose which					
	dessert they wan	t. One cart had 5 bowls					
	1	e on the bottom tier, 8					
		ldle tier, and 2 bowls of					
		top tier. The cart in the					
	side dining room	-					
		one cupcake on the top					
		ier had 3 bowls of red					
	•	the bottom tier had 1					
	-	ueberry cobbler on it. All					
	of these desserts	observed had nothing					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155786	B. WIN			04/27/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ALLISON	IVILLE MEADOWS				ALLISONVILLE RD RS, IN 46038		
	•				(O, IIV +0000		
(X4) ID PREFIX		CV MUST BE REDCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
1710	covering them.	ESC IDENTIFICATION ORGANIZATION	+	1710			BITTE
	covering them.						
	In an interview v	vith the Dietary Manager					
		23 A.M. she indicated					
		should have all of their					
		hair net. She further					
		es not usually cover the					
	1	want a fine dining					
	_	heir residents. In an					
	interview with the Executive Director on						
	4/25/12 during the exit conference at 3:20						
		d they never cover their					
		indicated they have no					
	1	to the covering of the					
	food.						
	In an intervious v	vith the Maintenance					
		/12 at 10:23 A.M. he					
	_	on should not be kept					
		ner of brown sugar on the					
	Cottage Unit.						
	In a policy provi	dad by the Executive					
		ded by the Executive /12 at 9:15 A.M. titled					
		ol" dated 2/02 with					
		3/04, 5/06, and 4/11, the					
		"c) All staff will wear					
		nt will cover all hair"					
		ng pertaining to the					
	covering of food						
	"Dotail Eard Est	ablishment Sanitation					
	effective 11/13/0	tle 410 IAC 724"					
	enective 11/13/0	4 mulcates the					

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Event ID: FFN111

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PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	r í	E SURVEY PLETED
		155786	A. BUILDING			7/2012
			B. WING	ADDRESS, CITY, STATE, ZIP C		
NAME OF I	PROVIDER OR SUPPLIE	R		ALLISONVILLE RD	ODE	
ALLISON	IVILLE MEADOWS	}		RS, IN 46038		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	following:					
	protected from conf. (1) packaging line, or salad bar	od on display shall be contamination by the use g; (2) counter, service r food guards; (3) display er effective means"				

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Event ID: FFN111

Facility ID: 012466

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
155786		A. BUILDING		04/27/2012	
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		ALLISONVILLE RD	
ALLISON	IVILLE MEADOWS		FISHEI	RS, IN 46038	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		<u> </u>	TAG	DEFFERRET	DATE
F0431 SS=E	& BIOLOGICAL The facility must services of a lice establishes a sy and disposition of sufficient detail to reconciliation; an records are in or controlled drugs periodically reconciliation and accepted profess the appropriate instructions, and applicable. In accordance with facility must biologicals in locinory temperate authorized personal authorized personal facility must permanently afficiency. The facility must permanently afficiency of controlled compressions and of the Comp	DS, LABEL/STORE DRUGS S It employ or obtain the ensed pharmacist who estem of records of receipt of all controlled drugs in to enable an accurate and determines that drug rader and that an account of all is maintained and			
	facility uses sing distribution systems	gle unit package drug ems in which the quantity al and a missing dose can be			
	record review, the accurately label	ration, interview, and ne facility failed to 1 of 3 open multiple dose ith an open date. This	F0431	what corrective action will be accomplished for those reside found to have been affected be deficient practice? On 5/8 2012 the SDC inserviced all nursing.	nts y 2

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Event ID: FFN111

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00			COMPLETED	
		155786	B. WING 04/27/2012			04/27/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				ALLISONVILLE RD	
ALLICON						
ALLISON	IVILLE MEADOWS			FISHER	RS, IN 46038	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		DD F F I Y (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	deficient practice	e had the potential to			staff on tubersol viles and the	
	•	new residents admitted to			dietary supplement feeding for	
	•	oril, 2012 who required			resident 123. All tubersole vil	es
					and dietary supplements are	
		esting. The facility failed			labeled with open dates.2. How	N
	_	el 2 of 2 open multiple			other residents having the	
	dose dietary supp	plement bottles [Resident			potential to be affected by the same deficient practice will be	
	#123] with an op	en date, and 1 of 2 open			identified and what correction	
	multiple dose die	etary supplement bottles			action will be taken.All residen	ts
	*	lentifier. This deficient			have the potential to be	
	practice was obs				affected.On 5/8 2012 the SDC	
	^				inserviced all nursing staff on	
	medication refrig	gerator.			tubersol viles and the dietary	
					supplement feeding . All	
	Findings include	:			tubersole viles and dietary	
					supplements are labeled with	
	1. On 4/23/12 at	11:00 A M the			open dates.3. what measures	
		or provided a copy of the			be put into place or what syste	
					changes will be made to ensur	
		nissions" ad requested			that the deficient practice does not recur?SDC will continue to	
	_	the facility. At that			inservice nursing staff on making	
	time, the "April 2	2012 Admissions" were			sure tubersole and dietary	
	reviewed. The fa	acility had 16 new			supplements are dated and	
		ed in the month of April.			labeled with open date.4. How	the
		equired tuberculin skin			corrective actions will be	
		equired tuberedim skin			monitored to ensure the deficie	ent
	testing.				practice will not recur?To ensu	
					compliance a medication stora	
		:00 A.M., tour of the			review CQI tool will be utilized	
	medication room	was initiated with			all nursing staff to be performed	
	Licensed Practic	al Nurse [LPN] #7.			each shift and given tothe DO	
					dailey for 30 days and bi-mont for one month and then month	
	On 4/26/12 at 11	:05 A.M., 1 of 3 open			therafter for six months. The	ıy e
		_			results of these audits will be	
		[Tuberculin Purified			reviewed by the CQI committe	e
	Protein Derivativ	ve] was observed without			overseen by the ED. If thresho	
	an open date.				of 100% is not achieved an ac	
					plan will be developed to assu	
	At that time in a	n interview, LPN #7			compliance.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

		TION NUMBER:	A. BUILDING B. WING	00	COMPLETED 04/27/2012			
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038					
(X4) ID PREFIX TAG	SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF	PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	indicated the open date sho on each open bottle of med #7 disposed of the vial of to 2. On 4/26/12 at 11:10 A.M. ounce dietary supplement to Berry Aloe Vera] was obset without an open date for Reand a 33.8 fluid ounce dieta bottle [Pure Aloe Force] was empty without an open date identifier. At that time, in an interview indicated she was not awar Aloe Force was prescribed all medications must be accellabeled. 3.1-25(j) 3.1-25(k) 3.1-25(l)	w, LPN #7 e who the Pure to and knew						

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Event ID: FFN111

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	COMPLETED	
		155786	B. WIN			04/27/	2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER							
					ALLISONVILLE RD			
ALLISON	VILLE MEADOWS			FISHER	RS, IN 46038			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	BROWINED'S BLAN OF CORDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
F0441	483.65	•						
SS=E		NTROL, PREVENT						
00-L	SPREAD, LINEN							
		establish and maintain an						
	•	Program designed to						
		anitary and comfortable						
	•	I to help prevent the						
		d transmission of disease						
	and infection.	u transmission of disease						
	and injection.							
	(a) Infection Con	trol Program						
		establish an Infection						
	Control Program							
		controls, and prevents						
	infections in the							
	` '	t procedures, such as						
		be applied to an individual						
	resident; and							
	` '	ecord of incidents and						
	corrective action	s related to infections.						
		pread of Infection						
	` '	ection Control Program						
		a resident needs isolation to						
	prevent the spre	ad of infection, the facility						
	must isolate the	resident.						
	(2) The facility m	ust prohibit employees with a						
	communicable d	isease or infected skin						
	lesions from dire	ct contact with residents or						
	their food, if direct	ct contact will transmit the						
	disease.							
	(3) The facility m	ust require staff to wash their						
	hands after each	direct resident contact for						
	which hand wash	ning is indicated by accepted						
	professional prac							
	(c) Linens							
		handle, store, process and						
	•	so as to prevent the spread						
	of infection.							
		ation and interview, the	F04	41	what corrective action will be accomplished for those regides		05/27/2012	
	facility failed to	ensure the ice scoop was			accomplished for those resider	เเร		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPL	COMPLETED		
I 155786		B. WIN			04/27/	2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ALLISONVILLE RD		
ALLISON	IVILLE MEADOWS	3			RS, IN 46038		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	not stored inside	e of 1 ice chest, on 1 of 5			found to have been affected b	У	
	units. The defic	eient practice had the			the deficient practice? SDC	_	
	potential to affe	ct 14 residents who			inserviced all staff on 5/8/12 o properly storing of the ice scool		
	resided on the 4	00 unit of 120 residents			when not in use. 2. How other	JP	
	currently residir	ng in the facility and who			residents having the potential	to	
	were provided i	-			be affected by the same defici		
	provided it				practice will be identified and		
	Findings include	۵٠			what correction actions will be		
	Findings include	5 .			taken? All residents have the		
	0 4/04/10	0.00 A.M			potential to be affected. SDC inserviced all staff on properly		
		0:00 A.M., environmental			storing of the ice scoop when		
		ed with the Maintenance			in use. 3. What measures will		
	Supervisor.				put in place or systemic chang		
					will be made to ensure that the	Э	
	On 4/24/12 at 10	0:30 A.M., a portable ice			deficient practice does nopt recur? continued inservices		
	chest cart was o	bserved in the hallway on			regarding infection control not	iust	
	the 400 unit. Th	ne scoop used to obtain			limited to ice scoops will be he		
	the ice from the	chest was inside the			on a monthly basis to ensure		
	container, and p	ositioned on top of the			compliance. 4. How the correct		
	ice.				action will be monitored to ensethe deficient practice will not	sure	
					recur? A resident round CQI to	ool	
	In an interview	at that time, the			which includes monitoring of the		
		pervisor indicated nursing			ice chest and proper placeme		
		llowed to store the scoop			of the ice scoop will be utilized	l by	
		The scoop was removed			the management team 3 times	_	
		_			week for the first month and to a week for the second month		
		est, and both the scoop and			then weekly thereafter, the res		
		hen removed from the unit			of these audits will be reviewe		
	1 -	ctical Nurse #2 for			by the CQI committee oversee		
	cleaning.				by the ED. if the threshold of		
					100% is not achieved an actio		
	3.1-18(b)(1)				plan will be devloped to assure compliance.	e	
					compliance.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00			COMPLETED		
		155786	B. WING			04/27/2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
4111001	\				ALLISONVILLE RD		
ALLISON	VILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F9999							
	State Finding:		F99	99	1. How corrective actions will be	ne .	05/27/2012
	State Finding.				accomplished for those reside	-	00/2//2012
					found to have been affected by		
	3.1-14 PERSON	NEL			deficient practice? Staff memb		
					4,5,6 were restarted on the		
	(t) A physical ex	camination shall be			PPD's. 2. How other residents		
		employee of a facility			having the potential to be affect	cted	
	•	prior to employment.			by the same deficient practice		
	` ′				be identified and what correction	ons	
	The examination				actions will be taken? SDC		
	tuberculin skin te	est, using the Mantoux			inserviced all staff that TB test	ing	
	method (5 TU PF	PD) The tuberculin skin			must be completed in a timely		
	`	prior to the employee			manner. the first step will be do		
	starting work	prior to the employee			before hire, and the second ste		
	_				will be done two weeks follow	-	
		re workers who have not			first step. a schedule has been		
	had a documente	d negative tuberculin			created by SDC, and for those who do not show up for second		
	skin test result du	aring the preceding			step will be removed from pay		
	twelve (12) mont	ths, the baseline			3. what measures will be put in		
	` ′	esting should employ the			place or what systemic change		
		. If the first step is			will be made to ensure that the		
	•	-			deficient practice does not reci		
	negative, a secon				SDC will monitor schedule of a		
	performed one (1) to three (3) weeks after			new hires to ensure 2nd step is	s	
	the first step				being administered timely. 4. F	How	
	_				the correction actions will be		
	This state rule wa	as not met as evidenced			monitored to ensure the deficie	ent	
		as not met as evidenced			practice will not recur.		
	by:				SDC Employy mantoux		
					scheduled will be monitored b	У	
	Based on record	review and interview, the			the DON on a weekly basis to	to.	
	facility failed to	provide employees with			ensure compliance. The result of the guidit will be reviewed by		
		erculin skin test method			of the audit will be reviewed by the CQI committee overseen by		
		red by Indiana State			the ED. If threshold of 100% is	•	
	_				not achieved an action plan wi		
	•	ealth. The second			be devloped to assure		
		est was not completed			compliance.		
	within 1 to 3 wee	eks after the first			· '		

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					(X3) DATE		
		A. BUII	DING	00	COMPL		
155786			B. WIN			04/27/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
A	IV.// F NAFA DOVA/O				ALLISONVILLE RD		
	IVILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DLI ICILICE I		DATE
		est. This deficient					
	1 ^	3 of 15 employee files					
		pational Therapist #6,					
	~	e # 5, and Certified					
	Nursing Assistan	nt #4]					
	Findings include	:					
	On 4/26/12 at 2:0	00 P.M., facility					
		s were reviewed.					
	r ry						
	At that time, the	employee records of					
	Occupational Th	erapist [OT] #6,					
	Registered Nurse	e [RN] #5, and Certified					
	Nursing Assistan	nt [CNA] #4 were					
	reviewed.						
	OT #6's "Tuberc	ulin Testing For					
	Employees" date	ed 2/6/12, included, but					
	was not limited t	o, "Hire date: 2/8/12					
	Date/Time Giver	n [step one]: 2/6/12					
	Date Read: 2/8/	12 Result: 0					
	millimeters Re	test of Mantoux (Step 2):					
	no documentatio						
	OT #6's "Tuberc	ulin Testing For					
	Employees" date	ed 3/12/12, included, but					
	was not limited t	o, "Hire date: 2/8/12					
	Date/Time Given [step one]: 3/12/12						
	Date Read: 3/15						
	millimeters Re	test of Mantoux (Step 2):					
		n [step 2]: 3/28/12					
	Date Read: 3/30						
	millimeters"						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
	155786		B. WIN	2012			
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	£		10312 A	ALLISONVILLE RD		
	IVILLE MEADOWS			FISHER	RS, IN 46038		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	RN #5's "Tuberc	•					
	Employees" date	ed 11/21/11, included but					
	was not limited t	to, "Hire date: 11/21/11					
	Date/Time Giv	ven [step one]:					
	11/21/11 Date	Read: 11/23/11 Result:					
	0 millimeters. F	Retest of Mantoux (Step					
	2): no document	· -					
	2). no document	atton noted					
	RN #5's "Tuberc	ulin Tasting For					
		•					
		ed 1/10/12, included, but					
		to, " "Hire date: 11/21/11					
		ven [step one]: 1/10/12					
	Date Read: 1/12	2/12 Result: 0					
	millimeters Re	test of Mantoux (Step 2):					
	Date/Time Giver	n: 1/27/12 Date Read:					
	1/30/12 Result	: 0 millimeters"					
	CNA #4's "Tube	rculin Testing For					
		ed 2/8/12, included, but					
		to, "Hire date: 1/11/12					
		n [step one]: 2/8/12					
	Date Read: 2/10						
		test of Mantoux (Step 2):					
		n: 2/13/12 Date Read:					
	2/15/12 Result	: 0 millimeters"					
	On 4/26/12 at 3:30 P.M., during daily exit conference, other tuberculin skin testing						
		om the Executive					
	_	ng the above employees.					
	2.100tol logulali	and and the employees.					
	On 4/27/12 at 0.1	30 A.M. in an interview,					
	uie Executive Di	rector indicated he did					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155786		LDING	00 	COMPL 04/27/	ETED
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS			•	10312 A	ALLISONVILLE RD RS, IN 46038	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	not have any furt provide for the a	ther documentation to bove employees.					
	3.1-14(t)(1)						

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